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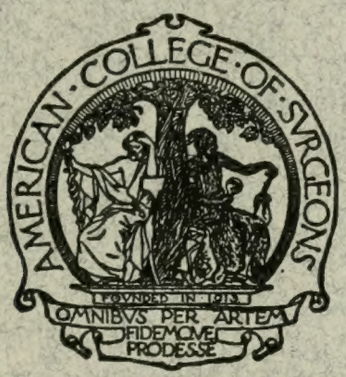
OF THE

AMERICAN COLLEGE of SURGEONS

VOL. X OCTOBER, 1926 NO. 4



PUBLISHED QUARTERLY BY THE
AMERICAN COLLEGE OF SURGEONS
40 EAST ERIE STREET :: :: CHICAGO

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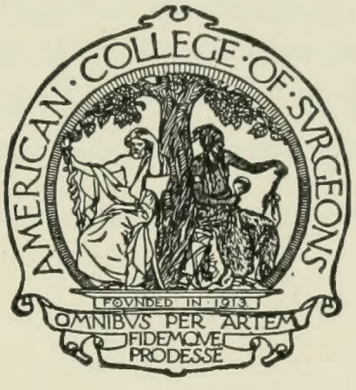

AMERICAN COLLEGE OF SURGEONS
40 EAST ERIE STREET :: :: CHICAGO

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CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS

RUDOLPH MATAS, New Orleans, *President* WALTER W. CHIPMAN, Montreal, *President-Elect*
FRANKLIN H. MARTIN, Chicago, *Director-General*

MONTREAL COMMITTEE ON ARRANGEMENTS

ALFRED T. BAZIN, *Chairman* EDWARD B. CHANDLER, *Secretary*

WALTER W. CHIPMAN, EDMOND M. EBERTS, ALFRED FERRON, A. MACKENZIE FORBES, FRASER B. GURD, STEPHEN LANGEVIN, ALBERT LASSALLE, DAVID W. MACKENZIE, OSCAR F. MERCIER, EUGENE SAINT-JACQUES, WILLIAM G. TURNER

COMPLETE PLANS FOR THE CLINICAL CONGRESS IN MONTREAL

AT 9:30 o'clock on Monday morning, October 25th, in Windsor Hall at the Windsor Hotel in Montreal, the sixteenth annual Clinical Congress of the American College of Surgeons convenes, the first session being the annual hospital conference at which the problems related to the College's work in the standardization of hospitals will be presented and discussed, as outlined in the program appearing in the following pages.

At the Presidential meeting on Monday evening in Windsor Hall, the President-Elect, Dr. Walter W. Chipman of Montreal, will be inaugurated, succeeding Dr. Rudolph Matas of New Orleans in that office. The John B. Murphy oration in surgery will be delivered at that session by Professor Archibald Young of the University of Glasgow, Scotland.

Clinics and demonstrations at the hospitals and medical schools will provide an interesting clinical program for the mornings and afternoons of the four days, Tuesday to Friday, inclusive. For the evening sessions the Executive Committee of the Congress has provided programs of unusual interest.

Two series of demonstrations or "dry clinics" form an important feature of the clinical program. One series, which will be of particular interest to the general surgeons, gynecologists, obstetricians, orthopedic and genito-urinary surgeons, will be held in Windsor Hall on Tuesday, Thursday, and Friday afternoons and at the University of Montreal on Wednesday afternoon. The second series of demonstrations is of special interest to those engaged in the practice of surgery of the eye, ear, nose, and throat, which sessions are to be held in Windsor Hall on Wednesday, Thursday, and Friday mornings, supplementing the clinical work in those branches to be given in the hospitals each afternoon.

General headquarters for the Congress will be established at Windsor Hotel on Dominion Square, where the Windsor Hall, Prince of Wales Salon, Rose, Blue and Oak rooms, and other large rooms and foyers located on the ground floor have been reserved for the exclusive use of the Congress. These rooms provide ample space for the evening meetings, business sessions, hospital conferences, registration and ticket bureaus, bulletin rooms, etc. Headquarters will be open for registration at eight o'clock on Monday, October 25th.

The preliminary clinical program, published in the following pages, as arranged by the Committee on Arrangements, of which Dr. Alfred T. Bazin is Chairman, has been largely revised in recent weeks and is to be still further revised and amplified previous to the Congress, so that the final program of clinics and demonstrations will adequately represent the clinical activities of Canada's great medical center. The actual program of the Congress is to be issued daily during the session, giving in complete detail a description of the clinics and demonstrations at the several hospitals and medical schools. This program will be issued in the form of bulletins posted each afternoon at headquarters for the following day's clinics. A printed program will be issued each morning. The clinical program for Tuesday will

be posted during Monday afternoon and reservations for tickets for Tuesday's clinics may be filed late that afternoon.

The annual meeting of the Fellows of the College will be held in Windsor Hall on Thursday afternoon at 2:30 o'clock, to be followed by the annual meeting of the Board of Governors.

HOSPITAL CONFERENCE

The annual hospital standardization conference will begin at 9:30 Monday morning in Windsor Hall at the Windsor Hotel. The preliminary program therefor will be found in the following pages. The recently formed Montreal Hospital Council, of which Dr. A. K. Haywood, Superintendent of the Montreal General Hospital, is chairman, is putting forth every effort to make this conference a great success. Montreal, with its extensive and modern hospital facilities, is a most suitable place for such a meeting. Trustees, superintendents, physicians, nurses, hospital personnel and others will be more than repaid through the practical benefits to be derived therefrom.

A four-day program will be presented, consisting of interesting and practical symposia and hospital demonstrations. The symposium on nursing, arranged for Monday afternoon, at 2 o'clock in Windsor Hall, will be a joint conference of physicians, nurses and hospital people. Discussion will cover the several viewpoints of the medical profession, the hospital group and the nurses themselves. Noted leaders in the nursing profession of the United States and Canada will be present. It is hoped that such a conference will be of constructive value in promoting better team-work among the three groups primarily interested in the best care of the patient. This is probably the first time an opportunity, on so large a scale, has been afforded for such a purpose. It is believed the discussion will bring forth a solution of the many questions related to nursing standards, nursing education and the present trend of nursing service.

On Tuesday, the morning session will be devoted to a most interesting round table conference, at which a number of practical problems will be presented and discussed. The afternoon session will be given over to a second symposium dealing with the care of the industrially injured or ill coming under the provisions of workmen's compensation laws. This will be discussed by many leaders in the medical and hospital professions, as indicated in the program which follows.

Attention is particularly directed to the symposium dealing with the standardization of ophthalmological and oto-laryngological departments in general hospitals, to be held on Wednesday morning. The interest aroused last year in this respect assures most constructive discussions in the way of improving these departments in general hospitals.

A particularly attractive feature of the conference this year will be the program to be carried out on Wednesday and Thursday, when a series of practical studies and demonstrations will be carried out in several of the Montreal hospitals. The development in Montreal hospitals during the past few years has been remarkable, and today a person may readily observe all phases of hospital planning, construction, organization and management in a model way. These practical demonstrations will be of great value to all who can be present on this occasion.

SPECIAL TRAIN FROM CHICAGO

For the convenience of Fellows residing in the central and western states who will attend the meeting in Montreal, the Michigan Central and Canadian Pacific railways will undertake to provide a special train leaving Chicago at 10:05 a.m. on Sunday, October 24th, arriving in Montreal at 8:15 a.m. on Monday. The equipment of this special train will equal that used for the fastest trains between Chicago and New York, and will include club, compartment, observation, standard Pullman sleeping and dining cars. The arrangement is contingent upon reservations for such special train being made by the minimum number required by the Interstate Commerce Commission rules. No extra fare will be charged. Fellows are urged to make their reservations for this special train at the earliest possible date.

REDUCED RAILWAY FARES

The railways of the United States and Canada have authorized reduced fares on account of the Montreal session of the Clinical Congress, so that the total fare for the round trip will be one and one-half the ordinary first-class one-way fare. To take advantage of the reduced rates it is necessary to pay the full one-way fare to Montreal, procuring from the ticket agent a "convention certificate" when purchasing the ticket, which certificate is to be deposited at headquarters for the visé of the special agent of the railway companies. Upon presentation of viséed certificate to the ticket agent in Montreal not later than November 2 a ticket for the return journey by the same route as traveled to Montreal may be purchased at one-half the regular one-way fare.

In the eastern, central, and southern states and eastern provinces of Canada tickets may be purchased between October 21 and 27; in southwestern and western states between October 19 and 25 and in the far western states and western provinces of Canada between October 15 and 21. The return journey from Montreal must be begun not later than November 2.

The reduction in fares does not apply to Pullman fares, nor to excess fares charged for passage on certain trains. Local railroad ticket agents will supply detailed information with regard to rates, routes, etc. Stop-overs on both the going and return journeys may be had within certain limits.

Full fare must be paid from starting point to Montreal, and it is essential that a "convention certificate" be obtained from the agent from whom the ticket is purchased. These certificates are to be signed by the general manager of the Clinical Congress and viséed by a special agent of the railroads in Montreal during the meeting. No reduction in railroad fares can be secured except in compliance with the regulations outlined and within the dates specified. It is important to note that the return trip must be made by the same route as that used to Montreal and that the certificate must be presented and return ticket purchased not later than November 2.

MONTREAL HOTELS AND THEIR RATES

The five principal hotels of Montreal as listed below afford accommodations for fully 3,000 persons. The number of single rooms available is limited and it is expected that the visiting surgeons will arrange to use double-bedded rooms, sharing accommodations with associates or friends. Since the 1920 session in Montreal, a new hotel has been erected, the Mount Royal, on Peel Street two blocks north of the Windsor Hotel, with upwards of one thousand rooms. All of the hotels listed with the exception of the Place Viger are within short walking distances of headquarters. Rates at the several hotels are as follows:

	Minimum Rates	
	Single Room	Double Room
Windsor, with bath	$4.00	$7.00
with running water	3.00	5.00
Mount Royal, with bath	4.00	7.00
Ritz-Carlton, with bath	6.00	10.00
Queen's, with bath	4.00	6.00
with running water	2.50	5.00
Place Viger, with bath	4.00	8.00
without bath	3.00	5.00

LIMITED ATTENDANCE

Attendance at the Montreal session will be limited to a number that can be comfortably accommodated at the clinics, the limit of attendance being based upon the result of a survey of the amphitheaters, operating rooms, and laboratories in the hospitals and medical schools as to their capacity for accommodating visitors. Under this plan it will be necessary for those who wish to attend to register in advance. When the limit of attendance has been reached through such advance registration, no further applications will be accepted.

Attendance at clinics and demonstrations will be controlled by means of special clinic tickets, which plan has proved an efficient means of providing for the distribution of visiting surgeons among the several clinics and insures against overcrowding, as the number of tickets issued for any clinic is limited to the capacity of the room assigned to that clinic.

REGISTRATION FEE

A registration fee of $5.00 is required of each surgeon attending the annual Clinical Congress, such fees providing the funds with which to meet the expenses of the meeting. To each surgeon registering in advance a formal receipt for the registration fee is issued, which receipt is to be exchanged for a general admission card upon his registration at headquarters during the meeting. This card, which is nontransferable, must be presented to secure clinic tickets and admission to the evening meetings.

PROGRAM FOR EVENING MEETINGS

IN WINDSOR HALL AT THE WINDSOR HOTEL AT 8 P.M.

Presidential Meeting—Monday, October 25

Address of Welcome: ALFRED T. BAZIN, M.D., Chairman of Montreal Committee on Arrangements.

Remarks by SIR ARTHUR WILLIAM CURRIE, G.C.M.G., K.C.B., LL.D., Principal of McGill University.

Address of Retiring President: RUDOLPH MATAS, M.D., New Orleans.

Introduction of Foreign Guests.

Inaugural Address: WALTER W. CHIPMAN, M.D., F.R.C.S. (Edin.), Montreal.

The John B. Murphy Oration in Surgery: "Sir William Macewen and the Glasgow School of Surgery." ARCHIBALD YOUNG, M.B., C.M., F.R.F.P.S., Glasgow, Scotland.

Tuesday, October 26

PROFESSOR ROBERTO ALESSANDRI, Rome: Tumors in Bones of Thyroid and Parathyroid Type, without Lesion of the Thyroid Gland.

WILLIAM J. MAYO, M.D., Rochester, Minnesota: The Cancer Problem.

W. SAMPSON-HANDLEY, M.S., F.R.C.S., London: Progress in the Treatment of Breast Cancer.

ROBERT B. GREENOUGH, M.D., Boston: Summary Report of the Committee on the Treatment of Malignant Diseases with Radium and X-ray.

Wednesday, October 27

EVARTS A. GRAHAM, M.D., St. Louis: Recent Additions to our Knowledge of the Gall Bladder.
Discussion: EDWARD ARCHIBALD, M.D., and E. M. EBERTS, M.D., Montreal.

Skin Grafting and Plastic Surgery:
GORDON B. NEW, M.D., Rochester, Minnesota: Plastic Surgery of the Face.
JOHN STAIGE DAVIS, M.D., Baltimore: Transplantation of Skin.

Plastic Surgery of the Hand:
SUMNER L. KOCH, M.D., and ALLEN B. KANAVEL, M.D., Chicago: Dupuytren's Contracture.
ARTHUR STEINDLER, M.D., Iowa City, Iowa: Restoration of Function by Orthopedic Operation.
HENRY H. M. LYLE, M.D., New York: Prevention of Loss of Function in the Hand by the Early Use of Skin Plastics.
STERLING BUNNELL, M.D., San Francisco: Restoration of Tendons and Nerves.

Thursday, October 28

JOHN M. C. FRASER, M.D., F.R.C.S. (Edin.), Edinburgh: The Involuntary Nervous System in Relation to Abdominal Disease.

Symposium: Sterility in Men and Women.
EDWARD L. KEYES, M.D., New York: Sterility in Men.
ROBERT T. FRANK, M.D., New York: The Differentiation of Endocrine and Mechanical Causes of Sterility in Women.
JOHN OSBORN POLAK, M.D., Brooklyn: Clinical Studies in Sterility in Women.

Convocation—Friday, October 29

Conferring of Honorary Fellowships.

Presentation of Candidates for Fellowship.

Presidential Address: WALTER W. CHIPMAN, M.D., F.R.C.S. (Edin.), Montreal.

Fellowship Address: SIR EWEN J. MACLEAN, F.R.C.P. (Lond.), F.R.S. (Edin.), Cardiff, Wales.

PRELIMINARY CLINICAL PROGRAM — GENERAL SURGERY, GYNECOLOGY, OBSTETRICS, ORTHOPEDICS, UROLOGY

MONTREAL GENERAL HOSPITAL

Tuesday

H. M. LITTLE—9. Operations: Ectopic gestation, pelvic inflammations.
F. J. TEES—9. Demonstration: Injury to elbow with late ulnar nerve lesion (5 cases).
E. M. EBERTS—10. Demonstration: Unusual types of thyroid disease; two cases of acute traumatic tension; pneumothorax.
F. J. TEES and F. B. GURD—10. Fracture clinic.
A. T. BAZIN—10:30. Operations: Gall-bladder disease, carcinoma of rectum.
L. J. RHEA and associates—10:30. Clinical pathological conference.
J. G. W. JOHNSON—11. Cranial injuries.
J. A. NUTTER—2. Orthopedic clinic, operations for paralytic deformities.
F. J. TEES and F. B. GURD—2. Fracture clinic.
L. H. MCKIM—3. Operative treatment of infections and compound injuries of hand and upper extremity.

Wednesday

F. S. PATCH and R. E. POWELL—9. Operations: Prostatectomy, nephrectomy.
F. J. TEES—9. Demonstration: Fractures of ankle and wrist.
A. T. BAZIN—10. Demonstration: Suppurative joint lesions.
F. J. TEES and F. B. GURD—10. Fracture clinic.
E. M. EBERTS—10:30. Operations: Radical cure of inguinal hernia by infolding muscular stitch, under local anæsthesia; excision of cæcum for carcinoma.
L. J. RHEA and associates—10:30. Clinical pathological conference.
C. K. P. HENRY—11. Demonstration: End-results of splenectomy in pernicious anæmia.
J. A. NUTTER—2. Orthopedic clinic, operations for congenital deformities.
F. J. TEES and F. B. GURD—2. Fracture clinic.
W. L. BARLOW—3. Excision of tongue for carcinoma.

Thursday

H. M. LITTLE—9. Gynecological operations for repair of birth injuries.
F. B. GURD—9. Demonstration: Fractures of femur and patella.
L. H. MCKIM—10. Demonstration: Wound infection in appendicitis.
F. J. TEES and F. B. GURD—10. Fracture clinic.
A. T. BAZIN—10:30. Operations: Radical cure of hernia by fascial graft; carcinoma of colon.
L. J. RHEA and associates—10:30. Clinical pathological conference.
J. A. NUTTER—11. Demonstration: Backache, sciatica, sacro-iliac and lumbosacral lesions and spondylolisthesis.

Friday

F. S. PATCH and R. E. POWELL—9. Urological operations.
A. T. BAZIN—9. Demonstration: Bone tumors.
F. J. TEES and F. B. GURD—10. Fracture clinic.
E. M. EBERTS—10:30. Operations: Thyroidectomies.
L. J. RHEA and associates—10:30. Clinical pathological conference.

WESTERN DIVISION

F. B. GURD and associates—9, daily. General surgical and gynecological operative clinics.
F. B. GURD and associates—2, daily. Demonstrations of end-results on fractures of the ankle, tibia and fibula, femur, humerus, etc.

NOTRE DAME HOSPITAL

Tuesday

O. F. MERCIER, U. GARIÉPY, and L. BLAGDON—9. Fracture clinic: Presentation of a personal technique and instrument for temporary metallic osteosynthesis; demonstration and report of cases.
T. PARIZEAU, J. A. DEMERS, and O. A. GAGNON—9. Surgery of the gall bladder; operations and demonstration of specimens.
L. DE L. HARWOOD, A. ETHIER, R. TRUDEAU, H. AUBRY, and L. GÉRIN-LAJOIE—9. Gynecological clinic: Operations and demonstration of cases.
E. A. RENÉ DE COTRET and staff—9. Obstetrical clinic: Puerperal infection, bedside work, demonstrations.
J. A. PANNETON—9. X-ray demonstration, routine work with exhibition of special technique and films. Iodeikon in gall-bladder diseases; lypiodeon in bronchial and lung diseases.
DR. BELLEROSE and staff—9. Routine work of out-patient department.
NOÉ FOURNIER—9. Urological out-patient clinic.

Wednesday

L. DE L. HARWOOD, A. ETHIER, R. TRUDEAU, H. AUBRY, and H. GÉRIN-LAJOIE—9. Gynecological clinic.
B. G. BOURGEOIS and O. MERCIER, JR.—9. Urological operations, suprapubic cystostomy and prostatectomy; anæsthesia in urology.
E. A. RENÉ DE COTRET and staff—9. Obstetrical clinic.
O. F. MERCIER, U. GARIEPY and L. BLAGDON—9. Fracture clinic; demonstration of apparatus on different cases.
J. A. PANNETON—X-ray demonstration, routine work with exhibition of special technique and films. Iodeikon in gall-bladder diseases; lypiodeon in bronchial and lung diseases.
DR. BELLEROSE and staff—9. Surgical out-patient clinic.
NOÉ FOURNIER—9. Urological out-patient clinic.

Thursday

L. PARIZEAU, C. A. GAGNON, and J. A. DEMERS—9. Surgical operations: Gastro-enterostomy; appendectomy.
L. DE L. HARWOOD, A. ETHIER, R. TRUDEAU, H. AUBRY, and L. GÉRIN-LAJOIE—9. Gynecological clinic.
B. G. BOURGEOIS and O. MERCIER, JR.—9. Importance of the catheterization of the ureters in tests of renal function; demonstration of cases.
O. F. MERCIER, U. GARIEPY, and L. BLAGDON—9. Abdominal complications in stasis of right hemicolon. Operations: Sympathectomy, blood transfusion.
J. N. ROY—9. Dry clinic; plastic surgery.
J. A. PANNETON—9. X-ray demonstration, routine work with exhibition of special technique and films. Iodeikon in gall-bladder diseases; lypiodeon in bronchial and lung diseases.
DR. BELLEROSE and staff—9. Surgical out-patient clinic.
NOÉ FOURNIER—9. Urological out-patient clinic.

ROYAL VICTORIA HOSPITAL

Tuesday

EDWARD W. ARCHIBALD and staff—9. General surgical clinic.

D. W. MACKENZIE and staff—9. Urological clinic, operations and demonstration of cases.

Wednesday

C. B. KEENAN and staff—9. General surgical clinic.

W. G. TURNER and W. J. PATTERSON—9. Orthopedic clinic, operations and demonstration of cases.

Thursday

F. A. C. SCRIMGER and staff—9. General surgical clinic.

D. W. MACKENZIE and staff—9. Urological clinic, operations and demonstration of cases.

Friday

FRANCIS C. MCKENTY and staff—9. General surgical clinic.

W. G. TURNER and W. J. PATTERSON—9. Orthopedic clinic, operations and demonstration of cases.

ROYAL VICTORIA HOSPITAL—MONTREAL MATERNITY PAVILION

Tuesday

W. W. CHIPMAN and H. M. LITTLE—9. Gynecological and obstetrical clinic, operations and demonstration of cases.

Wednesday

H. C. BURGESS and J. R. FRASER—9. Gynecological and obstetrical clinic, operations and demonstration of cases.

Thursday

J. R. GOODALL and J. W. DUNCAN—9. Gynecological and obstetrical clinic, operations and demonstration of cases.

Friday

W. W. CHIPMAN and W. A. G. BAULD—9. Gynecological and obstetrical clinic, operations and demonstration of cases.

ROYAL VICTORIA HOSPITAL—PATHOLOGICAL INSTITUTE

Wednesday

E. H. MASON—9. Pre-operative preparation of the diabetic patient with discussion of so-called "diabetic gangrene."

J. C. MEAKINS—9. Medical indications for splenectomy. Respiratory abnormalities in regard to the operative risk.

D. S. LEWIS—9. Relation of hypertension to surgical risk.

C. F. MOFFATT—9. Relation of cardiac disease to surgical operative risk.

Thursday

DAVID BALLON—9. The bronchoscopic injection of lipiodol as an aid to X-ray diagnosis of pulmonary lesions. Combined bronchoscopic and X-ray demonstration.

A. H. PIRIE—9. Demonstration of lungs injected with lipiodol in bronchiectasis and other diseases. Normal abnormalities of bones.

E. C. BROOKS—9. Report on 100 cases in which tetraiodophenolphthalein was given by mouth, with operative and other findings.

Friday

E. W. ARCHIBALD, F. A. C. SCRIMGER, D. ROSS, GAVIN MILLER, JOHN ARMOUR—9. Experimental surgery.

HOTEL DIEU HOSPITAL

Tuesday

PIERRE Z. RHEAUME and JOSEPH A. ST. PIERRE—9. Surgical operations: Appendectomy for appendicitis, chronic and possibly acute; cholecystectomy; enteroanastomosis; hysterectomy; fracture of the femur; fracture of the tibia, Delbet's walking splint.

EUGENE ST. JACQUES, DONALD A. HINGSTON, and WILLIAM J. DEROME—2. Clinical demonstration: Trauma of the hip; heliotherapy in the treatment of osseous tuberculosis as practiced at Leysin and Davos, Switzerland; pituitary gland, clinical pathology; limited indications and multiple contra-indications of uterine curettage.

LEO PARIZEAU—2. X-ray demonstration.

Wednesday

EUGENE ST. JACQUES, DONALD A. HINGSTON, and WILLIAM J. DEROME—9. Surgical operations: Demonstration of the advantages of the Reverdin needle and self retractors in diminishing the number of assistants; hysterectomy for fibroma; hysterectomy for salpingo-ovaritis; thyroidectomy; cholecystectomy; fracture of the patella, Delbet's method.

PIERRE Z. RHEAUME, JOSEPH A. ST. PIERRE, and Professor BARIL, biochemist—9:30. Clinical demonstration: Intestinal tuberculosis; stricture of the œsophagus; ovarian conservation; uterine fibroma and pregnancy; thyroid pathology; some clinical aspects of splenomegaly; value of the Ambard test in estimating the kidney function.

Thursday

EUGENE ST. JACQUES, DONALD A. HINGSTON, and WILLIAM J. DEROME—9. Surgical operations: Appendectomy; cholecystectomy; gastro-enterostomy; hysterectomy; thyroidectomy; application of starch bandages in trauma of the forearm; Delbet's walking splint in fracture of the leg.

Friday

PIERRE Z. RHEAUME and JOSEPH A. ST. PIERRE—9. Surgical operations: Prostatectomy; removal of stone in the bladder; intestinal resection; nephropexy; nephrotomy for stone in kidney; hysterectomy; appendectomy.

MISERICORDIA HOSPITAL

Tuesday

STEPHEN LANGEVIN—9. White asphyxia and cerebral injuries.

H. LEBEL—10. Protection of child in breech extraction.

L. JUITRAS—11. Pernicious anæmia and blood transfusion.

Wednesday

D. MARION—9. Control of eclampsia by intravenous injection of somnifene.

D. RICARD—10. Syphilis and pregnancy.

STEPHEN LANGEVIN—11. Cranial injuries.

Thursday

STEPHEN LANGEVIN—9. Hirudo medicinalis (leeches) in femoral thrombophlebitis.

P. GAUTHIER—10. Pernicious vomiting and blood grouping.

D. MARION—11. Eclampsia and cæsarean section, radical treatment.

CHILDREN'S MEMORIAL HOSPITAL

Tuesday

A. MacKenzie Forbes, R. Deromel, K. Cameron, and F. Yorston—10. Operations: Cleft palate, hernia. Demonstrations: Application of extension in fractures, application of extension in tuberculous hip.

Wednesday

A. MacKenzie Forbes, R. Deromel, K. Cameron, and F. Yorston—10. Operations: Tendon transplantation, reduction of congenital dislocation of hip. Demonstration: Scoliosis and its treatment.

Thursday

A. MacKenzie Forbes, R. Deromel, K. Cameron, and F. Yorston—10. Operations: Harelip, sequestrotomy, correction of deformities due to club feet. Demonstration: Routine examination of children suffering from tuberculous bones and deformities following acute anterior poliomyelitis.

Friday

A. MacKenzie Forbes, R. Deromel, K. Cameron, and F. Yorston—10. Operations: Tonsillectomies, correction of deformities due to rickets. Demonstration: Preparation of plaster bandages and their proper application.

ST. JUSTINE HOSPITAL

Tuesday

A. Ferron, Z. Crepeault, and J. H. Rivard—9. Operative clinic: Harelip, undescended testicle, scoliosis.

Wednesday

E. Dube, A. Ferron, and J. H. Rivard—9. Operative clinic: Congenital dislocation of the hip, congenital hernia, Pott's disease.

Thursday

A. Ferron, Z. Crepeault, and E. Dube—9. Operative clinic: Cleft palate, prolapse of rectum, correction of club feet.

SURGERY OF THE EYE, EAR, NOSE, AND THROAT

CLINICAL DEMONSTRATIONS
in Windsor Hall

Tuesday, 9:30

Walter B. Lancaster, M.D., Boston: Orbital Conditions Arising from Rhinopharyngeal Disease.
Discussion opened by Charles T. Porter, M.D., Boston, and John M. Wheeler, M.D., New York.

William H. Luedde, M.D., St. Louis: Conditions of the Eyeball Arising from Rhinopharyngeal Disease.

Burt R. Shurly, M.D., Detroit: Chronic Rhinopharyngeal Disease.
Discussion opened by Herbert S. Birkett, M.D., Montreal.

Wednesday, 9:30

Symposium: The Standardization of Ophthalmological and Otolaryngological Departments in General Hospitals. (See program of hospital conference.)

Thursday, 9:30

Frank E. Burch, M.D., St. Paul: Glaucoma After Cataract Extraction.
Discussion opened by Harry V. Wurdemann, M.D., Seattle, Wash.

William T. Davis, M.D., Washington: Unilateral Atrophic Optic Neuritis.
Discussion opened by S. Hanford McKee, M.D., Montreal.

George L. Tobey, Jr., M.D., Boston: Subject to be announced.

Samuel Iglauer, M.D., Cincinnati: Injection of Lipiodol in the Diagnosis of Pulmonary Lesions. (Lantern slide demonstration.)
Discussion opened by David H. Ballon, M.D., Montreal.

Friday, 9:30

Fielding O. Lewis, M.D., Philadelphia: Treatment of Malignant Laryngeal Disease.
Discussion opened by Gabriel Tucker, M.D., Philadelphia.

Edward H. Cary, M.D., Dallas: Some Otological Problems.

Arthur J. Bedell, M.D., Albany: The Value of Microscopic Study of the Living Eye. (Lantern slides.)
Discussion opened by John A. MacMillan, M.D., Montreal.

Walter S. Franklin, M.D., San Francisco: Radium in Extra-ocular Conditions, with Report of Cases.

ROYAL VICTORIA HOSPITAL

Tuesday

David H. Ballon—2. Use of lipiodol in pulmonary diagnosis by the bronchoscopic method.

William J. McNally—2. Experimental work on labyrinth.

G. Edward Tremble—2. Nasal prosthesis.

Staff—2. Eye clinic, slit lamp demonstration.

Wednesday

E. Hamilton White—2. Tonsillectomy with demonstration of intratracheal anæsthesia.

J. T. Rogers—2. Immediate skin graft in radical mastoid; radical maxillary sinus operation under local anæsthesia.

A. G. McAuley—2. Cryptic intra-ocular sarcomata, lantern slide demonstration.

J. A. MacMillan—2. Wound infections of the eyeball, lantern slide demonstration.

Friday

Prof. H. S. Birkett, E. H. White, J. T. Rogers, D. H. Ballon, G. E. Tremble, K. Hutchison, William J. McNally—2. Ear, nose, and throat clinics, operations and demonstrations of cases.

Staff—2. Eye clinic, slit lamp demonstration.

MONTREAL GENERAL HOSPITAL

Tuesday

H. D. Hamilton and staff—9. Nose and throat clinic, operations and demonstration of cases.

G. E. Hodge and V. Heney—2:30. Bronchoscopic clinic, demonstration of cases.

C. J. Stewart—2:30. Tonsillectomy under gas anæsthesia.

Wednesday

G. H. Mathewson and S. H. McKee—2:30. Eye clinic.
H. Baby—2:30. Zinc ionization in chronic otorrhœa, technique and demonstration of cases.
A. E. Lundon—2:30. Nasal prosthesis (lantern slides).
J. B. Gallagher—2:30. Brain abscess.

Thursday

H. D. Hamilton and staff—9. Nose and throat clinic, operations and demonstration of cases.

Friday

G. H. Mathewson and S. H. McKee—2:30. Eye clinic.
A. W. Furness—2:30. Labyrinthine tests as an aid in diagnosis of intracranial lesions, demonstration of cases.
A. O. Freedman—2:30. Salivary gland tumors.

HOTEL DIEU HOSPITAL

Tuesday

Albert Lassalle—2:30. Dacryocystorhinostomy (Dupuy-Dutemps technique): operation followed by demonstration with lantern slides.
F. Badeaux—2:30. A rare case of conjunctivitis, with discussion.

Wednesday

J. P. E. Bousquet—2:30. A new method of operation on the frontal and ethmoidal sinuses; operation under local anæsthesia.
G. Badeaux—2:30. Twenty cases of thrombophlebitis of the jugular vein, with discussion.

Friday

Albert Lassalle—2:30. Reconstruction of the lachrymal ducts by dermo-epidermic graft; demonstration with lantern slides.
J. P. E. Bousquet—2:30. Ocular muscular imbalance; demonstration with living cases.

NOTRE DAME HOSPITAL

J. N. Roy. Melanosarcoma of limbus. Technique for saddle nose.
P. Panneton. Technique of hearing test. Case of cataract extraction (combined) by trauma.
J. Brault. Case of lipoma of the bulbar conjunctiva.

HOSPITAL STANDARDIZATION CONFERENCE

Preliminary Program

Windsor Hall—Monday, October 25—Morning Session, 9:30

Chairman: Rudolph Matas, M.D., New Orleans, President

Opening Address by the President.

The Montreal Hospital Council. A. K. Haywood, M.D., Superintendent, Montreal General Hospital; Chairman, Montreal Hospital Council.

Presentation of the Official Report of Hospital Standardization for the Year 1926. Franklin H. Martin, M.D., Chicago; Director-General, American College of Surgeons.

The Minimum Standard as a Factor for Better Surgery. William J. Mayo, M.D., Rochester.

The Minimum Standard as Applied to the Department of Internal Medicine. Charles F. Martin, M.D., Montreal; Dean, Faculty of Medicine, McGill University, Representing the American College of Physicians.

Educational Opportunities of Hospital Standardization. Edward A. Fitzpatrick, Ph.D., Milwaukee; Dean of Graduate School, Marquette University.

The Trustee's Opinion of Hospital Standardization. Robert Wood Johnson, New Brunswick, N. J.; President of Board of Trustees, Middlesex General Hospital.

Impressions of a New Zealander on Hospital Standardization. L. E. Barnett, M.D., Dunedin, New Zealand; Emeritus Professor of Surgery, Otago University Medical School.

General discussion.

Afternoon Session, 2:00

Joint Conference on Nursing—Nursing Standards, Nursing Education, Nursing Service. Conducted by A. K. Haywood, M.D., Superintendent, Montreal General Hospital.

Nursing as a Service Profession. W. W. Chipman, M.D., Montreal; Professor of Gynecology and Obstetrics, McGill University Faculty of Medicine; President-Elect, American College of Surgeons.

What the Medical Profession Expects in the Nursing Care of the Patient. A. T. Bazin, M.D., Montreal; Professor of Surgery and Clinical Surgery, McGill University Faculty of Medicine.

(A) Nursing from the Standpoint of the Medical Profession

The Present Status of Nursing from the Viewpoint of the Medical Profession. John E. Jennings, M.D., Brooklyn; Surgeon, Brooklyn Hospital.

Discussion opened by L. J. Austin, M.D., Kingston; Professor of Clinical Surgery, Queen's University Faculty of Medicine.

(B) Nursing from the Standpoint of the Hospital

The Present Status of Nursing Service from the Viewpoint of the Hospital Superintendent. JOHN E. DOUGHERTY, M.D., Brooklyn; Superintendent, Jewish Hospital; and JOSEPH J. BAKER, Brooklyn; President, Board of Directors, Jewish Hospital.

Discussion opened by LOUIS C. TRIMBLE, New York City; Superintendent, New York Post-Graduate Medical School and Hospital.

(C) Nursing from the Standpoint of the Nursing Profession

A Standardization Program for Schools of Nursing. LAURA R. LOGAN, R.N., Chicago; Dean, Illinois Training School for Nurses.

Discussion opened by GRACE M. FAIRLEY, R.N., London, Ontario; Superintendent of Nurses, Victoria Hospital.

The Relationship of the State Department of Education to Hospitals Through their Registered Schools of Nursing. ALICE S. GILMAN, R.N., Albany; Secretary, State Board of Nurse Examiners, University of the State of New York.

Discussion opened by FLORA M. SHAW, R.N., Montreal; Director of School for Graduate Nurses, McGill University.

Hourly or Group Nursing. JANET M. GEISTER, R.N., New York City; Assistant Executive Secretary, Associated Out-Patient Clinics of the City of New York.

Discussion opened by CARRIE M. HALL, R.N., Boston; President, National League of Nursing Education.

General discussion and round table conference.

Tuesday, October 26—Morning Session, 9:30

Chairman: W. W. CHIPMAN, M.D., Montreal, President

Remarks by the Chairman.

Some Things Which Seem to be Lacking in Hospitals. REV. C. B. MOULINIER, S. J., Milwaukee; President, Catholic Hospital Association.

Special Problems and their Solution from a Survey of the Hospital Field. NEWTON E. DAVIS, Chicago; Corresponding Secretary of the Board of Hospitals, Homes and Deaconess Work of the Methodist Episcopal Church.

Round Table Conference—Conducted by O. F. MERCIER, M.D., Montreal; Professor of Clinical Surgery, University of Montreal Faculty of Medicine.

The Importance of Strict Operating Room Control. Discussion opened by SOUTHGATE LEIGH, M.D., Norfolk, Va.; Visiting Surgeon and Gynecologist, Sarah Leigh Hospital and Clinic.

A Successful Method of Analyzing Hospital Deaths. Discussion opened by W. FRANK FOWLER, M.D., Rochester, N. Y.; Attending Surgeon, Highland Hospital.

An Annual Medical Audit for Hospitals. Discussion opened by GEORGE GRAY WARD, M.D., New York City; Professor of Obstetrics and Gynecology, Cornell University Medical College.

Standardization of Hospital Sundries. F. H. SLAYTON, M.D., Pittsburgh; Mellon Institute of the University of Pittsburgh.

Open versus Closed Hospitals. Discussion opened by JOHN A. MCNAMARA, Chicago; Managing Editor, *The Modern Hospital.*

Basic Considerations and Requirements for : (a) Extension of Privileges to Doctors to Attend Private Patients in Hospitals; (b) Membership and Appointment to the Attending Staff. Discussion opened by ALLAN CRAIG, M.D., Chicago; Associate Director, American College of Surgeons, Director of State and Provincial Activities.

The Proper Conduct of the Staff Conference. Discussion opened by P. J. KEARNS, M.D., Montreal; Pathological Institute of McGill University.

Follow-up and End-Results. Discussion opened by STANLEY T. FORTUINE, M.D., Cambridge; Resident Surgeon, Mary McClellan Hospital.

Afternoon Session, 2:00

Symposium—A Minimum Standard for Hospitals in the Care of the Industrially Injured or Ill, Coming Under the Provisions of Workmen's Compensation Laws. FRANK D. JENNINGS, M.D., Brooklyn; Clinical Professor of Surgery, Long Island College Hospital, presiding.

Workmen's Compensation Laws, their Intent and Significance. CHARLES DECKELMAN, Hartford.
Discussion by HENRY D. SAYER, New York City; Former Industrial Commissioner, State of New York; and W. D. KINGSTON, Toronto, Industrial Commissioner, Province of Ontario.

Ambulance Service and First Aid. FREDERICK J. TEES, M.D., Montreal; Lecturer in Clinical Surgery, McGill University Faculty of Medicine.

Hospital Reception of Injured Workmen. G. W. MUNGER, M.D., Valhalla, N. Y.; Superintendent, Grasslands Hospital.

General and Special Features in Hospitals for Adequate Treatment of Industrial Patients.

The Essentials of a Complete Hospital Record of Industrial Patients. GEORGE G. DAVIS, M.D., Chicago; Assistant Clinical Professor of Surgery, Rush Medical College of the University of Chicago.

Co-operation Between Hospitals and Those Administering Workmen's Compensation Laws. FREDERIC A. BESLEY, M.D., Waukegan, Ill.; Professor of Surgery, Northwestern University Medical School.
Discussion by M. O. FOLEY, Chicago, Managing Editor, *Hospital Management.*

The Care of the Ambulatory Patient and Follow-up of Discharged Patients. S. POTTER BARTLEY, M.D., Brooklyn; Associate Professor of Surgery, Long Island College Hospital.
Discussion by JOHN E. RANSOM, Toledo; Superintendent, Toledo Hospital.

Wednesday, October 27—Morning Session, 9:30

Symposium—The Standardization of Ophthalmological and Oto-Laryngological Departments in General Hospitals. HERBERT S. BIRKETT, M.D., Montreal; Professor of Oto-Laryngology, McGill University Faculty of Medicine, presiding.

The Purpose of this Conference. M. T. MACEACHERN, M.D., Chicago; Associate Director, American College of Surgeons, Director of Hospital Activities.

Summary and Conclusions from Last Year's Conference Held in Philadelphia. JOSEPH C. BECK, M.D., Chicago; Associate Professor of Oto-Laryngology, University of Illinois College of Medicine.

Topics for Discussion: Planning, by EDWARD F. STEVENS of Stevens & Lee, architects, Boston and Toronto. Equipment, organization, administration, and service, discussed by EDWARD JACKSON, M.D., Denver; FRANK M. SULZMAN, M.D., Troy; HARRIS P. MOSHER, M.D., Boston; THOMAS H. HALSTED, M.D., Syracuse; and other ophthalmologists and oto-laryngologists.

Summary and Conclusions. CRAWFORD C. MCCULLOUGH, M.D., Fort William, Ontario; Ophthalmologist and Oto-Laryngologist, McKellar General Hospital.

Wednesday, October 27, and Thursday, October 28

A series of twenty most interesting and practical studies and demonstrations in Hospital Organization, Administration, Procedures, and Service have been arranged at the following hospitals in Montreal:

Montreal General Hospital—Central Division
Montreal General Hospital—Western Division
Royal Victoria Hospital
Hotel Dieu Hospital
Notre Dame Hospital
Children's Memorial Hospital
Shriners' Hospital
Ste. Justine Hospital
Hospital Français
Alexandra Hospital

Full particulars regarding each demonstration will be printed in the final program.

FRACTURE OF THE OS CALCIS*

By NATHANIEL ALLISON, M.D., Boston, Massachusetts

FRACTURE of the os calcis is not an uncommon fracture. Its frequency is that of about 2 per cent of all fractures. It is occasioned usually by a fall from a height, landing on the heel or heels. One or both os calces may be broken. This fracture constitutes one of the serious accidents of industry. The immediate results are those of painful disability; the ultimate result is impaired function. That the end-results are bad is perhaps not generally realized. Cotton has stated that 90 per cent of those who sustain this fracture are thereby more or less permanently disabled. This same observer with Henderson has reported the end-results in seventy-five cases and concludes the following: "Conservative treatment gives incredibly bad results. We must do better than this—it must be possible." Magnuson has estimated the ultimate loss of function after os calcis fracture as from 35 to 75 per cent, basing this finding on the reports of the Illinois Industrial Accident Board.

The Types of Os Calcis Fracture and Their Clinical Significance

Conn has recently classified the various types of os calcis fracture under five heads:

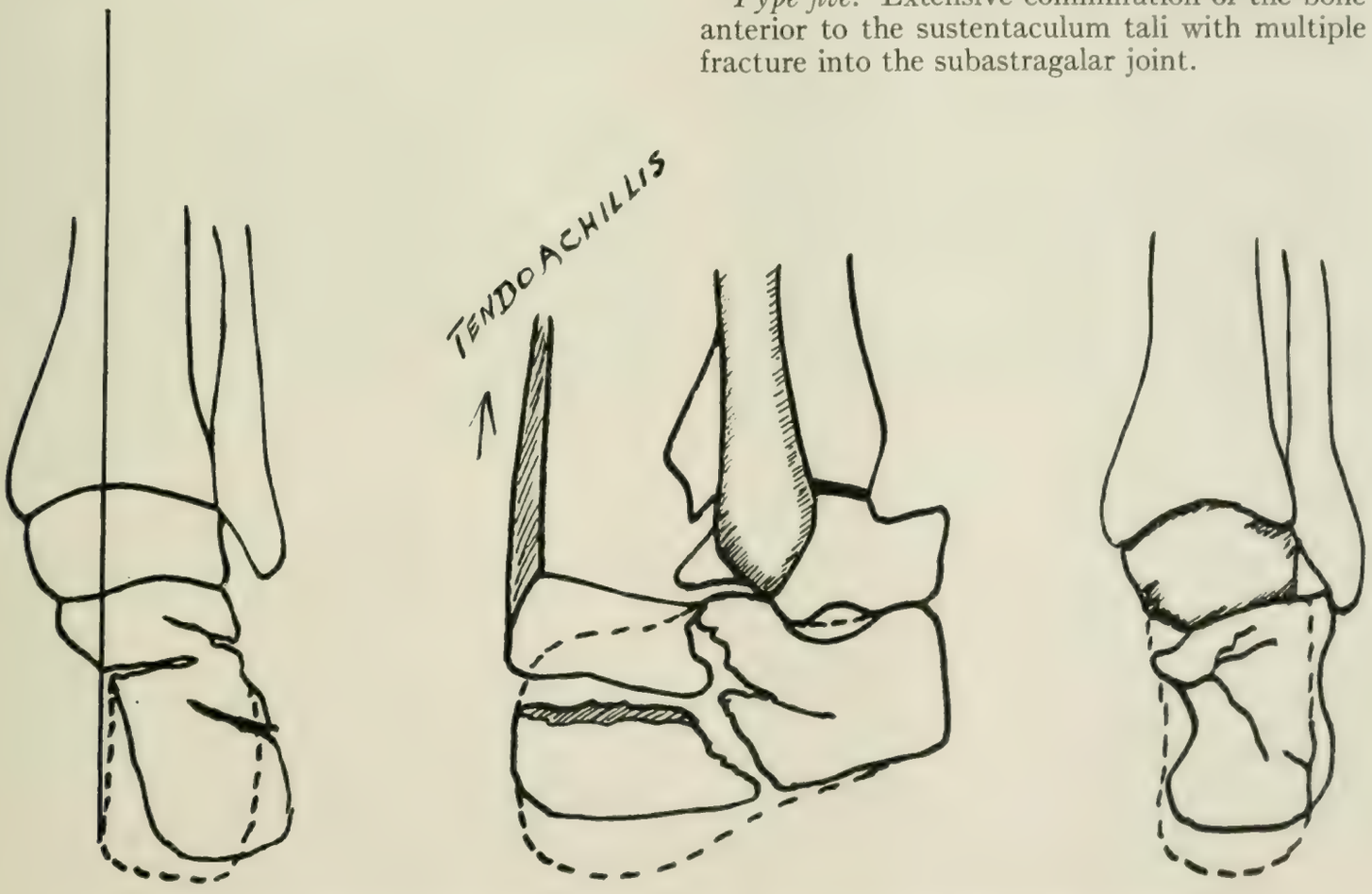
Type one. Impacted fracture producing eversion of the os calcis with mesial deflection of the weight bearing line, and without fracture into the subastragalar joint.

Type two. Comminuted fracture with upward displacement of the distal fragment, so that the posterior portion of the os calcis is pulled upward by the tendo Achillis, without fracture into the subastragalar joint.

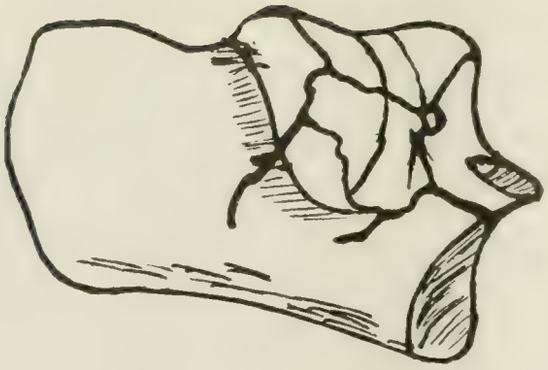
Type three. Impacted comminuted fracture resulting in shortening and thickening of the os calcis, so that a displaced bone mass impinges on the external malleolus, without fracture into the subastragalar joint.

Type four. Multiple fracture lines, some of which transverse the sustentaculum tali and which enter the subastragalar articulation.

Type five. Extensive comminution of the bone anterior to the sustentaculum tali with multiple fracture into the subastragalar joint.



*Approved for publication by the Committee for the Treatment of Fractures of the American College of Surgeons.



Clinical considerations demand effective treatment for each of these types. The first three types lend themselves to direct surgical attack which is designed to remould the fragments and secure them in the best position possible. The last two types, wherein the subastragalar joint is injured, demand for the restoration of useful function the ablation of this joint. Numerous and varied combinations of the above types occur.

Treatment. In suspected os calcis fracture, X-ray study is absolutely necessary. Plates should be taken which will show the presence or absence of both lateral and perpendicular deviations. The essential point to be observed is whether or not the subastragalar joint surfaces have been fractured.

For the severe types wherein the subastragalar joint is involved it is better to consider early arthrodesis of this joint with remoulding of the os calcis. Experience on the Fracture Service of the Massachusetts General Hospital justifies this statement. Seventeen patients out of a group of nineteen have been returned to useful function in six months' time without permanent disability.

For the milder type of injury, i. e., those in which the subastragalar joint is not fractured, various methods are useful. Cotton and Henderson have inserted a steel sound over the superior surface of the os calcis, anterior to the tendo Achillis, pulling downward on this and remoulding the bone. After reduction these observers advise impacting the fragments by striking the bone several sharp blows with a mallet. Foldes has used a traction apparatus to pull the posterior heel downward. Strauss has transfixed the fragments with a pin and pulled downward using the traction device of the Hawley table. Becker has exposed the under surface of the bone and used a lever to replace the fragments. Some writers advise lengthening the tendo Achillis; others advise against it. All agree that the lateral bone mass which impinges under the external malleolus demands removal either by excision of bone or remoulding. It is essential to remould the arch of the foot, and to use plaster of Paris dressing for retention after any type of operative interference.

Summary

Do not temporize and procrastinate in fracture of the os calcis. Surgical intervention is demanded in the majority of cases. Determine the nature and extent of the injury by careful X-ray study. Devise a method which will replace the fragments and restore the bone to as near normal as possible. In injury to the subastragalar joint, arthrodesis of this joint holds the best promise of a useful foot.

COMPRESSION FRACTURE OF THE SPINE*

"Crush Fracture"

By ROBERT B. OSGOOD, M.D., Boston, Massachusetts

THE important facts associated with compression fracture of the spine, so-called "crush fracture" of the spine, may be briefly assembled as follows:

They are common traumatic lesions of the spine. The possibility of their existence should be borne in mind in all cases of mild or severe trauma to the body and spine. Their detection requires careful examination and roentgenograms taken in two planes. If rational treatment is provided, early subsequent disability is unlikely. If rational treatment is not provided, early subsequent severe disability is common. Progressive disability, often impossible to completely relieve, may begin and continue in unrecognized or neglected cases after long periods of comparatively active life.

Etiology

These fractures are always caused by violence, but rarely if ever by direct violence at the region of the fracture. They are produced by forced hyperflexion of the spine by forces acting in the long axis of the spine when it is slightly flexed. Such forces would be represented by the fall of a heavy weight on the shoulders, by falls of the individuals from heights, landing on their feet or buttocks, and by crushing injuries which suddenly bend the spine sharply forward.

In the series of Sante and McCutchen and in Wallace's series, about 80 per cent of these fractures occur in the low dorsal and lumbar regions, one of the first two lumbar bodies most commonly yielding. Simple compression fractures of the cervical region are rare, but when they occur, paralytic symptoms are more often associated with them.

Signs and Symptoms

The most constant sign is rigidity of spine, often limited to a few vertebræ above and below the lesion.

The next most common sign is abnormality of contour of the spinous processes, usually represented by their greater prominence opposite the crushed vertebra. Often, however, there is no marked kyphos or knuckle. Disturbed reflexes, changes in sensation and weakness to paralysis of muscle groups are frequently found, but the point to emphasize is that they are frequently not found and their absence militates in no way against the existence of a possible crush fracture.

The commonest symptom is pain in the back near the region of the injury and pain on pressure on the spinous process of the affected vertebra. Pain may be the only symptom and pain itself is often only elicited by attempts at motion. Neuralgic and cramplike pain in the limbs is often present, but like the neurological signs, their absence by no means rules out the diagnosis of a compression fracture.

Diagnosis

History:—The story of any general "shaking up" or fall with or without subsequent symptoms referable to the spine and without regard to the severity or apparent triviality of the accident should always excite sufficient suspicion to demand a careful examination of the spine. Unless the contours are normal and the voluntary motions of all the segments are entirely free and without protective muscular spasm, roentgenograms of the entire spine in two planes, antero-posterior and lateral, should be studied.

There are so many cases in which the serious nature of the injury is masked by the absence of localizing symptoms and signs that thoroughness of examination needs to be emphatically stressed. Statistics strongly suggest that such thoroughness is wanting.

Usually a shrewd guess as to the nature of the injury may be hazarded by the history of immediate pain in the back, the more or less localized splinting of the spine by the muscles, tenderness to pressure in the region, especially to pressure on the spinous process of the affected vertebra. There is frequently an appreciable kyphos, not often sharp, but including three or four spinous processes. It is to be remembered in seeking to localize the lesion that the spinous process of the injured vertebra is usually the one directly below the apex of such a kyphos. Abnormal reflexes, disturbances of sensation and motion in the lower limbs, or a true paralysis will not be missed in any careful examination, but these signs are more often absent than present in compression fractures of the low dorsal and lumbar regions.

*Approved for publication by the Committee for the Treatment of Fractures of the American College of Surgeons.

Roentgenological Findings

Compression fracture, if it exists, will be evident in the roentgenograms which, let us say again, should be taken in the antero-posterior and lateral planes, and if there is evidence of severe comminution, stereoscopically as well.

In the antero-posterior view the affected body will appear narrowed and usually, but not always, somewhat broadened. If the direction of the rays is not parallel to the intervertebral discs and the crushed body is rotated downward, this narrowing may not be marked, since the posterior portion of the body may cast a deceiving shadow.

In the lateral view the wedge-shaped body is evident unless only one lateral margin of the vertebral body has been crushed, when the uncrushed lateral margin may cast a deceiving shadow.

As a rule, the intervertebral discs are unaffected. Occasionally the posterior common ligament may be torn and allow the elastic disc to protrude into the spinal canal to such an extent as to cause pressure on the cord or cauda equinæ.

Differential Diagnosis

(a) Tuberculosis of a vertebra is accompanied by rigidity of the spine and usually presents a kyphos, but before the collapse of the body occurs, there is a partial or total destruction of the intervertebral disc.

(b) Osteomyelitis of a vertebra, if the symptoms are acute and associated with trauma, has marked constitutional symptoms and the vertebral body rarely collapses until late.

(c) Hypertrophic arthritis, Charcot's disease, Paget's disease, and malignant disease should rarely be confusing because of signs in these bone changes elsewhere in the body and the want of a history of definite trauma.

Treatment

(1) Cases seen immediately or soon after the accident.

Recumbency should be at once enjoined. A complete plaster of Paris jacket or better, in our opinion, double plaster shells extending from well above the lesion over the buttocks to just above the knees should be applied, well padded over bony prominences, but closely and smoothly fitted. The patient can be much more easily handled if he lies in his double shell on a Bradford frame. No violent attempt should be made to correct the deformity if one exists, but as complete extension of the spine as it is possible to secure without pain and without an anæsthetic should be attained before the shells are applied. In the high dorsal and cervical regions the posterior shell should include the head, and forward flexions of the cervical spine be prevented by a soft strap over the forehead. The patient lies in his posterior shell alone most of the time and may be turned for toilet of the back by strapping on the anterior shell, before he is carefully rolled over. In this anterior shell he lies while the back is bathed and any threatened decubitus is relieved.

The patient remains in these shells in complete recumbency for 8 to 10 weeks if all neurological signs are absent. He is then allowed to try sitting up in a well fitting and completely protecting jacket or brace and if protective muscle spasm remains absent he is gradually allowed on his feet. The jacket or brace we believe should be worn for at least four months from the time of injury and forced flexions of the spine prohibited.

In early cases thus treated the prognosis is almost completely favorable for a return to normal activity. We do not believe operative measures designed to stiffen the spine at the site of injury are indicated or even justifiable. Nature, if given a chance, will adequately protect the region by cementing the crushed vertebra to its adjacent fellows by the outgrowth of marginal exostoses and the residual stiffness is minimal.

(2) Cases seen several months after the accident.

These cases may well be subjected for a few weeks to the same type of protective recumbency described for the early cases. If, however, the signs and symptoms do not steadily improve, we believe a fusion or bone graft operation designed to completely protect by internal fixation the region of the injury is indicated and is justifiable. Disability time is lessened, and the danger of a rarefying osteitis (Kümmel's disease) or an excessive bony overgrowth is minimized.

THE INITIAL TREATMENT OF SIMPLE FRACTURES*

By GEORGE W. HAWLEY, M.D., Bridgeport, Connecticut

THE following rules are useful as a guide to the early treatment of simple fractures:

(1) Do not overlook the responsibility of making an early diagnosis.

(2) Treat every doubtful case as a fracture until proven otherwise. There is no credit in overlooking a fracture and there is no discredit in making the reverse mistake.

(3) Do not be deceived by the absence of deformity and disability. There are many cases of fracture in which ability to use the limb persists.

(4) Always use gentleness and care in handling any broken limb. Roughness is always inexcusable.

(5) Use only the simplest methods of examination for the diagnosis of fracture.

(6) Definite localized tenderness over a bone may be evidence of fracture.

(7) Never attempt to elicit crepitus.

(8) Disturb the patient and the injured part as little as possible.

(9) Always remember that a broken bone is exceedingly painful and any motion accentuates the pain.

(10) Limit manipulation to the correction of the most obvious deformities only.

(11) Have the permanent splint ready when the attempted reduction is made.

(12) Make it a practice to effectively splint a fracture using sufficient padding.

(13) Make it a duty to see that the patient has an early X-ray examination and competent treatment thereafter.

(14) Do not forget to look for more than one fracture as well as injuries to other parts of the body.

If these rules are followed, fewer mistakes in diagnosis will be made, much unnecessary pain will be avoided, much help will be given the surgeon responsible for the final treatment and much improvement will be found in the end-results.

*Approved for publication by the Committee for the Treatment of Fractures of the American College of Surgeons.

NURSING—HEARSAY AND FACTS IN PRIVATE DUTY*

By JANET M. GEISTER, R.N., New York, New York

SINCE the establishment of modern nursing, the nurse has always had a place of honor and trust in the community. Her patients and their families have held her in esteem and affection—she has enjoyed the confidence of those about her. The nurse, though often overworked and underpaid, found spiritual and mental satisfaction in the work to which she gave her devoted service, and she was happy.

In the past few years a note of discord has entered this happy relationship. This note becomes daily louder and more insistent. The old confidence between nurse and patient, between nurse and community, is being broken down. From the public we hear the cry that nurses are charging too much, that the twelve-hour nursing day works a hardship on the patient, that the nurse is less interested in her patient than formerly, that there are too few nurses.

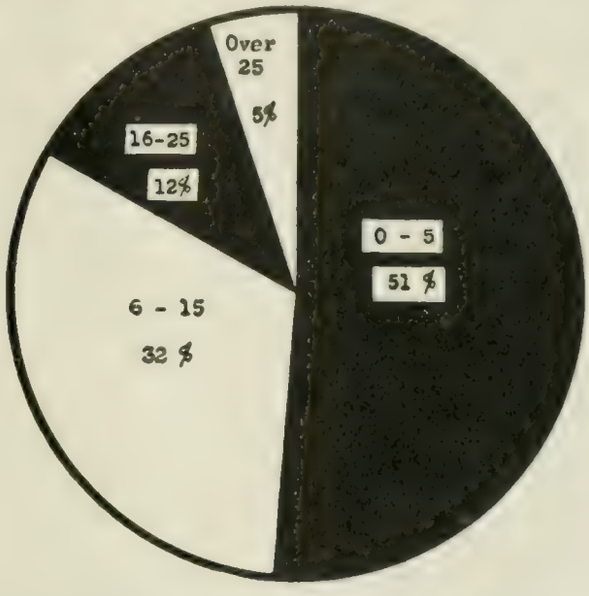
The medical profession is giving considerable thought to the matter; many committees have been appointed to study it. Some of the criticism that has been made is constructive and some destructive. Most of the remedies that have been offered are based on personal opinion and not on carefully assembled facts. The tendency has been to attack the nurse and not the problem. To indicate how far the pendulum has swung, we have only to cite an editorial in a recent local medical journal, which reads:

"Man's inhumanity to man makes countless thousands mourn," could well be paraphrased when applied to the nursing problem and made to read: "The average nurse's inhumanity to sick people makes countless thousands mourn." It would seem there is no longer but one thought in the minds of most nurses when called upon to take care of the sick, and that is the commercial side of the question.

The editorial quoted is indicative of much of the confusion in thought on the part of the public and of both the medical and nursing professions.

On the other hand, the activity of the Nurse Registry Committee of the Medical Society of the County of Kings, Brooklyn, New York, in working jointly with a committee from the State Nurses' Association to bring about a practical solution of the problem, is a notable instance of some of the thoughtful and constructive work that is going on.

The nurse herself is depressed and perplexed. We have no accurate data relative to the exodus from private duty nursing for the country at large, but if the results of two recent studies made in New York State are typical of the situation, then it is true that from 30 to 50 per cent of the nurses in private duty are planning to enter other fields. This is an extremely serious situation.



Per cent who have been in service each number of years. Data for 1,409 private duty nurses, New York State, February, 1926.

These studies are made under the auspices of the New York State Nurses' Association in coöperation with the Committee on the Grading of Nursing Schools. The first, which was largely preliminary, was made in September, 1925. The present study is one of a series of four to be made at intervals during 1926. The effort is to get at the facts of private duty nursing. Obviously the subject is so large that it was deemed wise to limit it to facts concerning the economics of private duty nursing—the number of days on duty, off duty, without call, the amount charged, cost of laundry, rents, and car fares.

Fifty Years Ago and Now

Why all this hue and cry about the private duty nurse? Has the time come when she must con-

*Address delivered before the Private Duty Section of the American Nurses' Association at the American Health Congress, Atlantic City, May 18, 1926. With permission of the author this address is published in this Bulletin as a matter of particular interest to Fellows of the American College of Surgeons, Hospital Trustees and Superintendents in view of the Joint Conference on Nursing to be held in Montreal, October 25, 1926, at the time of the Annual Hospital Conference of the American College of Surgeons.

sider radically changing her method of serving her patients? Private duty nursing today is still being done largely according to the methods instituted fifty or more years ago. The practice of having at least one nurse in constant attendance upon one patient was inaugurated in the days when women's services were plentiful and inexpensive. Housework, school teaching, and nursing were the three major occupations of woman. Competition for her service was far from keen, and therefore little effort was made to conserve it.

Hospitals in those days were few and unpopular, the majority of the sick preferred to be cared for in their own homes. Houses were larger, nearly every family had at least one spare room, and therefore the nurse could be accommodated more easily than she can in the small and crowded living quarters now made necessary by the congestion of population. Homes were more isolated, as telephones, automobiles, and good roads were scarce, and the patient consequently needed to be more constantly under skilled observation. There were fewer outside interests for the mother in the home; hence she nursed her own family and called for the skilled service of the trained nurse only when the situation got beyond her own skill.

Fifty years have brought about tremendous changes. Women, instead of having to rely upon only three occupations, can now choose from almost as large a variety as can men. Their work in both professional and non-professional pursuits is being better compensated and the hours and conditions of work have proportionately improved. As a consequence, the training school superintendent now faces keener competition than she formerly faced for service of high ability.

Changes in medical practice have been as marked as changes in general conditions of living; and the type of nursing that is required has been changed accordingly. Sanitary science and the advancement of medical science have changed the character of illness in our communities; and the ambulatory patient is getting as much attention as is the one acutely ill.

Meanwhile, improvement in the quality of hospital care has made it increasingly popular and the combination of medical demand and popular approval has removed many sick patients from their homes to the specially equipped institution. About three-fifths of all the cases reported in the Februrary study were in the hospital, and only two-fifths in the home. There is some reason to believe, too, that as our public comes more and more to demand comforts and luxuries, there is an increased tendency within the home to place the responsibility for any needed nursing care, however minor, on a nurse, rather than to have this service rendered, as of old, by some member of the family.

The nurse has followed the patient and as new hospitals are being built, many nurses who formerly spent their lives in the homes of their patients are now filling executive and special positions in hospitals. The development of public health nursing has drawn off another large quota. Therefore, not only competition in other fields, but competition within the nursing field itself, has drawn heavily from the ranks of private duty nursing. Partly because the adventurous nurse could leave the private duty field for these other opportunities, the fact has been obscured that conditions of service in the private duty field, in comparison with those of other occupations, have become increasingly unsatisfactory. Now, however, the alleged shortage of nurses in private duty is forcing facts into the open and focusing attention upon them.

Unorganized, Unsupervised, Outgrown

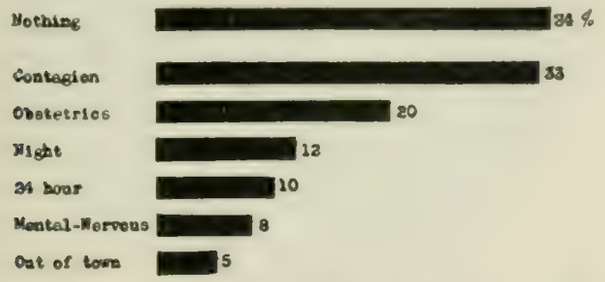
In considering these facts it is sharply borne upon us that, surrounded by changes in the social and economic position of women, in the practice of medicine itself, private duty nursing is following practically the lines laid down for it fifty years ago. To blame the nurse for this is futile—the physician and the public are equally responsible.

When there is sickness in the home the demand for a nurse carries with it the assumption that the patient requires skilled nursing service twenty-four hours a day and that there must be a nurse in constant attendance. Furthermore, the tendency on the part of the intelligent employer of labor and the intelligent director of professional workers to conserve the health of their workers through limiting working hours, good working conditions, and other means, has not affected the private duty nurse.

It is a curious fact that while the public is being more and more exhorted to live a well balanced regular life of work, play, love, and worship, the general attitude is to consider the private duty nurse the one exception to the groups that should carry out these rules. Her life isolates her from society, its irregularity breaks down her health, its seclusion tends to narrow her interests. She cannot charge in accordance with any particular skill she has acquired; she is unethical if, after ten years of hard work, she charges any more than does the newest graduate into the field. Yet she must be all things to all people, she must

remain human though she cannot live like most humans.

Modern business and professional groups distribute their resources over the largest possible area through organization. The school system is organized and the teacher serves thirty children, where, if she were not a part of an organization, she might serve but one. The fire department is



Per cent who register against each specified type of service. 34% do not register against anything. The "average registration against" is 1.4 per nurse. Data for 1,409 private duty nurses, New York State, February, 1926.

organized. When one's house is on fire, one does not send in a frantic call to a half dozen places to get a fireman who might for that moment be disengaged. The house might be in ashes before he was found. How many firemen would be found, if they had to wait around at their own expense until the fire occurred and then be paid, not in accordance with the skill they had acquired in years of service, but a flat rate of from $5 to $8 per day, depending upon the locality in which they served? Business is organized. Few of us could afford much in the way of food, clothing, books, etc., were we to purchase them by order from the lone shoemaker, farmer, weaver, or printer.

Furthermore, every industry has its superintendent; every school has its principal and its supervisors; every business has its department heads; our visiting nurse associations are strengthened immeasurably through their supervision. Through this supervision the nurse receives continuous education, continuous stimulation and continuous opportunity to develop her own ability, and she is able to render skilled nursing service to six or eight patients every day instead of to one.

When we speak of supervision we do not mean the rigid militaristic system of checking us up to see what we have not done. That is negative. Positive supervision is friendly, it brings to us the leadership of workers with special preparation and training and broad experience. It brings to us newer methods, newer knowledge. Constructive teaching supervision is essential in all fields. In private duty nursing, we are not organized on this basis; we are not organized at all. Each nurse deals individually with the individual patient—there is no central organization to spread her services over the greatest possible territory. There is no supervision. Supervision stops the day the nurse leaves her training school; she is as lone a worker at twenty-one as she is at forty.

This lack of supervision is not only a loss to the individual nurse but it permits conditions to obtain that would not endure under supervision The many splendid women in private duty nursing are judged, only too often, by the small group of nurses who do not practice according to the ideals or standards of the profession. Who is there today to keep the nurse who has unsuccessfully nursed ten patients from going in on the eleventh? Who is there today to guard the patient against the unscrupulous woman who dishonestly lays claim to nursing skill and who has been known, time and again, to charge double the fee of the graduate registered nurse?

Private duty nursing, as it is practiced today is extremely costly. This cost is borne by the patient and by the nurse. They both pay heavily for the waste in the system. There is no question in our minds but that the cost of having one or two special nurses, for a week or two weeks or three, is frequently beyond the means of the average man. His loved one is ill, nursing is needed, he can do nothing but accept the present system even though it cripples him financially.

Is the nurse the gainer? Our studies indicate that the cost to her of the present method is quite as heavy as it is to the patient. In the long run the cost to her is greater. During the last week of February this year, at the height of the busy season, the average private duty nurse in New York State earned $31.26 for her entire week's work. During this busy season, when many doctors were unable to secure the sort of nurses they needed for their patients, the average nurse in New York State worked only five days and earned only $31.26.

These figures came from the average private duty nurse who is charging from $5 to $7 daily. As a weekly income this salary contrasts unfavorably with that of every other professional group. Taken on a basis of the actual number of hours on duty the income is about even with that of charwomen, servants, and unskilled labor, who in many instances are receiving fifty cents per hour. The nurse's income per hour in the study averages about forty-nine cents. What, then, is

responsible for a situation costly to all participants? We must charge it up to the bad distribution, to the uneconomic use of nursing service.

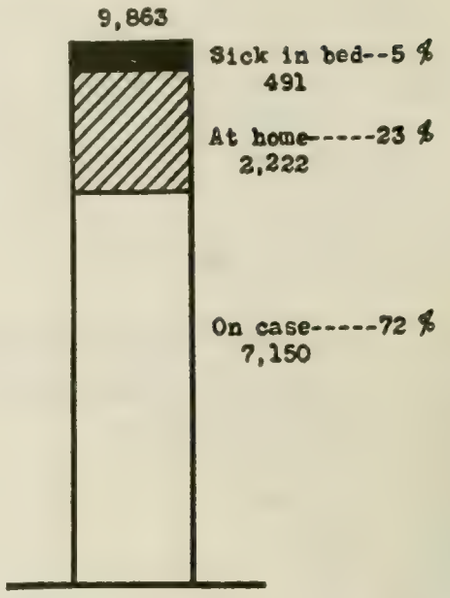
Waste of Nursing Skill

How many of our sick people, today, require twenty-four hours of skilled nursing service every day?

We have evidence to indicate that many sick people are daily getting along very well on one or two hours of skilled nursing service. The visiting nurse concentrates in the fifteen minutes to an hour that she spends in the home not only carefully planned nursing service, but teaching, too, in order that some one in the home can assume the responsibility for giving the patient the less skilled care he needs during the nurse's absence. That this service is satisfactory is attested to by the fact that every year sees an increase in the work of the 640 visiting nurse associations in this country. When a patient is so ill that the untrained person in the home cannot be charged with caring for him during the nurse's absence, and it is deemed unwise to remove him to the hospital, the visiting nurse association makes arrangements for a special twenty-four hour nurse to care for him during this crisis. The need for this service is strikingly small; it plays a very small part in the regular work of an association.

Do not think that the visiting nurse association serves only a selected group of patients. It cares for every type and manner of illness. The only restrictions occur when the local health departments do not permit nursing of certain kinds of contagious diseases, but these restrictions do not exist in all communities. The middle class family is being served by the visiting nurse as well as that of the poorer patient whose fee is remitted when he is unable to pay.

By nursing care we mean the duties that require the services of a trained nurse. A private duty nurse may keep herself busy the whole time she is in the home, but she may be performing duties that could be done quite as well by some other member of the family. Were the nurse engaged only for the number of hours necessary for the nursing care required by the patient, the old criticism that the nurse will not do housework or will not help out on other tasks, would automatically disappear. It is not that the nurse is unable to wash dishes or cook supper, but that her particular usefulness to her patient is her nursing skill. Why use her for other duties? Is it a responsibility of the nursing profession to solve the servant problem? The physician may be



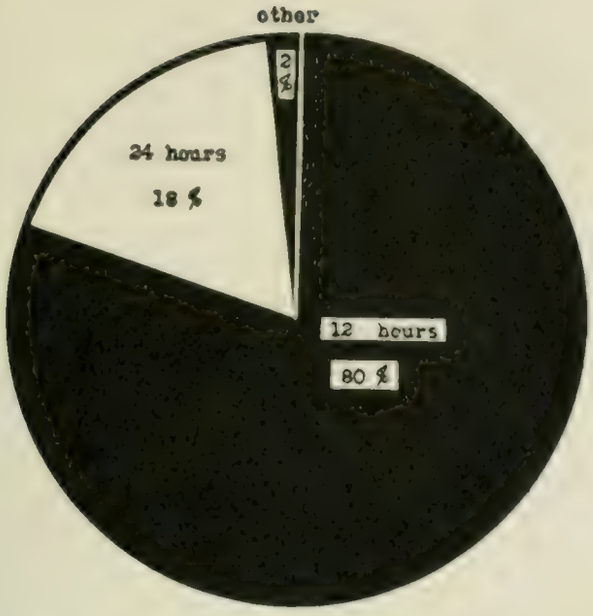
Where working days were spent. If 1,409 private duty nurses had worked seven days each, the total would have equaled 9,863 working days. During week, Feb. 21–28, 72% of these days were spent on case, 23% at home, 5% sick in bed. New York State, 1926.

skilled in wielding the razor but we do not expect him to shave the patient—his skill is in doctoring and he must devote his time to that.

Under the present system of twenty-four hours' constant service, the patient pays for many more hours of nurse attendance than he actually needs. At the same time while this service is being wasted in one home another family with an acute illness finds it impossible to get service; thus the waste is costly to the patient with the nurse, and costly too in risk to the patient without a nurse.

It is costly to the nurse for a number of reasons. The monotony of idle hours on duty—of being on hand twelve hours while her patient needs her but six, is demoralizing. The long day, fifteen and sixteen hours, sometimes, makes it practically impossible for her to have any outside interests. It tends to break her health and her spirit. The irregularity of her work precludes any opportunity for further study, for any participation in community activities. If there is no illness, there is no work for her. No one but the private duty nurse knows the anxiety of waiting for the summoning telephone to ring, especially during the dull season.

In our questionnaires we asked nurses to give their reasons if they were planning to go out of private duty. And even though the majority of them were averaging only forty-nine cents per hour, their first two reasons did not concern their incomes but were in regard to the irregularity of the employment and the length of the working



Length of working day, for cases cared for by 1,409 private duty nurses, Feb. 21–28. Of these cases $^3/_5$ were in hospital, $^2/_5$ in home. New York State, 1926.

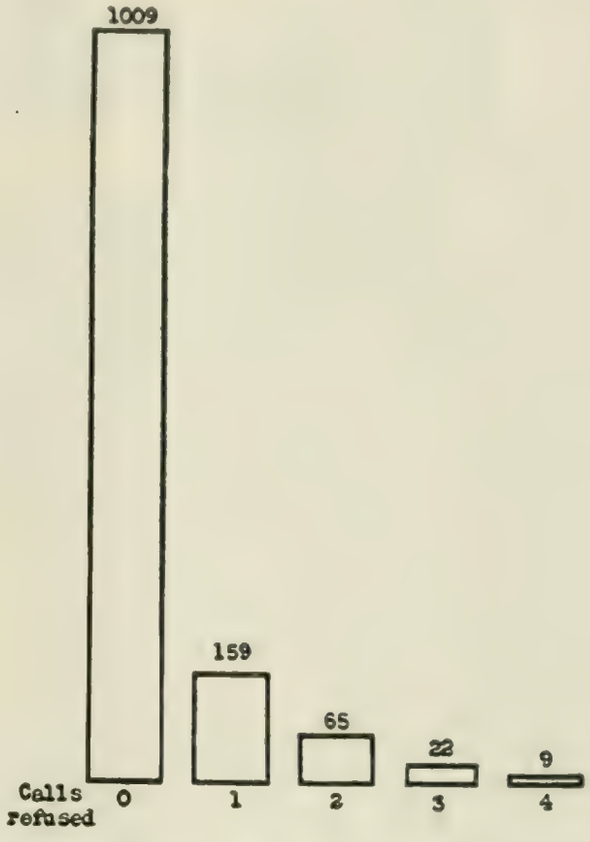
day. The nurse feels the sharp contrast between her isolated life and that of the women in other fields of activity who have regular employment seven hours a day, five and a half days a week; who are given holidays and vacations and sick leave on pay; who more often than not are receiving more compensation than is she; and who have their evenings free.

Irregular and Uncertain Employment

The private duty nurse herself bears the cost of every moment she is not working, of every day spent in resting after a particularly arduous case, of every day of waiting as a precautionary measure after a contagious case. We have reason to believe that this time amounts to about four months out of the year for the average nurse; making the $6.00 she receives for one day's work really cover one and one-third days of her life, or really making her day's earnings $4.00 when computed in terms of the time she had to wait for her case plus her hours on duty. Let no one believe that this four months' period of no work can be counted as leisure, permitting further study and recreation. It is broken up into irregular bits, a day here, a week there, much of which is spent in standing guard over the telephone waiting for the next call.

It is true that the nurse should be and is actuated by motives higher than that of material well-being alone. Were the money her only or her dominating thought, the inspiring record of selflessness and devotion in nursing never would have been written. The fact remains, however, that the cost of shoes and hats and coal and groceries and rent is the same for the nurse as it is for any other member of the community. In order to be self-sustaining she is forced to give consideration to this item. Society has made no provision for the woman who has given the best years of her life and the best of her strength in a service that too often leaves her broken in health and poor in purse.

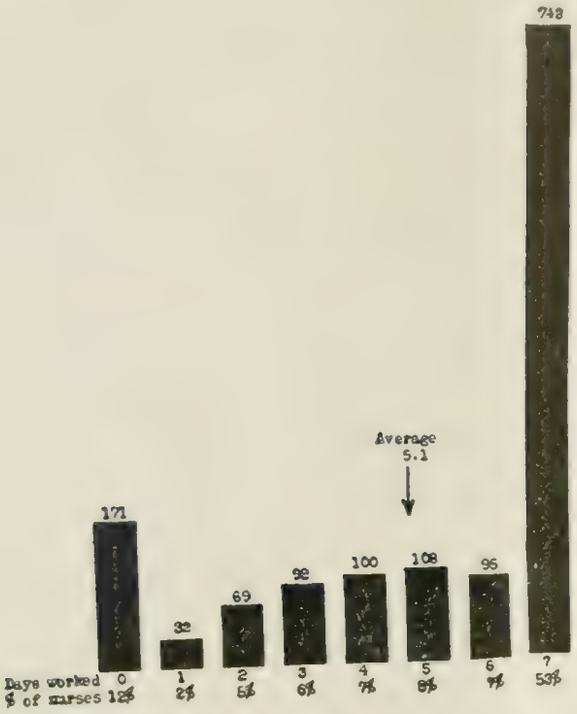
Probably the greatest cost of all to the nurse, and incidentally to the community as well, is the comparatively short period of years she is able to serve the community. Of the 1,400 women who answered the New York questionnaire, but 5 per cent had graduated prior to 1900. This gives



Nurses who refused each number of calls, during week Feb. 21–28, 1926. 80% did not refuse a single call. Data for 1,409 private duty nurses, New York State.

strength to the oft-repeated assertion that fifty years is the dead line in private duty. Fifty years of age, in most professions, marks the period when the varied experiences of the individual make him of greatest value to the community.

We are told, too, that frequently the older nurse is undesirable because she is irritable, does not easily adjust to difficult situations. What makes her so? Could her intensive life built on steadily living many hours a day with patients be responsible? Could it be because she finds herself in a blind alley job—a job that offers no pro-



Nurses who worked each number of days during the week, Feb. 21–28, 1926. 171 nurses, or 12%, did not work at all. 742, or 53%, worked seven days without stopping. 25% of all the nurses worked three days or less. Data for 1,409 private duty nurses, New York State.

motion, a job that offers no greater financial reward after twenty years of service than after twenty minutes? Could this fact have anything to do with her reputed irritability? Could the fact that her job gives her little opportunity for professional comradeship be responsible? She must work without the fellowship of her own professional group and therefore has little opportunity for exchange of ideas and for the stimulus of teamwork.

There is something seriously wrong in a method of work that takes such heavy toll from the worker. Yet, to the glory of the nursing profession, in spite of all the difficulties, all the hardships, nurses still want to nurse. Over and over and over again on the 1,400 questionnaires sent in by private duty nurses in New York State appear words like these:

I am planning to give up private duty only because I am forced to in order to save a little money. I don't want to give up nursing. I like actual nursing work better than anything else—there is nothing I want to do more.

The Nursing Shortage

We hear a great deal about the shortage of nurses. We always hear this at certain periods of the year when the peak load of sickness is high. Do we ever hear it in the months when there is little sickness? The public, in crying for more nurses during the few busy months, concerns itself not at all as to what happens to those nurses when there is no "flu" or pneumonia.

Much of the so-called shortage of nurses really is caused by waste of nursing service. How many patients who have special nurses in the hospitals today really need these nurses? Do all the patients who have two, three, or even four nurses need all of them? We have all seen corridors dotted with special nurses idly passing time because their patients did not need them, and then have heard in the administrative office the frantic efforts to get special nurses for seriously ill patients. We have all seen the patient who desires to show her financial standing by having two nurses idling about her room or her home. We have seen about us much luxury nursing where nurses are called upon to do glorified maid service. Who is responsible for this? Not the nurse. She does not beg to be put on these cases. We know that when she tries to get off these cases, in order to serve some more needful patient, she is called unprofessional, unethical.

Another great cause of the so-called shortage is the exceedingly bad distribution. While many nurses recognize the value of a central clearing house or central registry, and register for service accordingly, a large group operate as free lances. They get their calls from various sources, and the registry is not cognizant of their availability for service. Consequently we have the strikingly anomalous situation of hearing on one side the cry of a nurse shortage and on the other the complaint of nurses that they have been unemployed.

In the last week in Februrary, 1926, when the sickness load was heavy and the demand for nurses great, we find from our study that in New York State, 47 per cent of the nurses worked less than the full seven days. Twelve per cent worked not at all, while 25 per cent, or just one-fourth of all the nurses, were busy three days or less. Moreover, while the doctors were reporting a shortage, their calls for help never reached these available nurses. Just 80 per cent of the 1,400 nurses in New York State reported that they had not refused a single call during the week. This vividly illustrates the need for better distribution, for a central organization to connect the nurse and the sick patient. It illustrates the major weakness of the present system.

We are frequently told that the way to remedy the nursing situation is to increase the supply. Indeed, it is the prescription most often brought forth. Reduce the entrance requirements, cut down the theoretical training (which amounts on

the average to four hours a week), cut down the time of training, and the situation will be solved! The situation will never be solved while the conditions in the private duty field are so out of keeping with the world about us. What does it avail us to pour new wine into old bottles if the bottles are leaking? Why not stop the leaks first?

When a business house finds it has a heavy staff turnover each year, does it remedy the situation by bringing in fresh hordes of new workers? It does not. It makes a thoroughgoing canvass into the reasons for this turnover, for it finds it a far better investment to hold the workers already in the field than constantly to bring in new workers.

Radical Reorganization

What is the remedy for the situation? Clearly every fact points toward the inevitability of change in our present system. The patient, the doctor, the nurse, the community, are all dissatisfied with the present order of things. The cost to the patient and the nurse is inordinate, yet no one is the gainer. A continuation of the present system would result undoubtedly in a very real shortage of nurses with a consequent rise in price of nursing to the consumer. Is it not possible to bring skilled nursing service to the patient in the quantity and quality he needs and at the same time insure to the nurse a decent standard of living, a life more in keeping with life about her, a life with hope of a professional future? We believe it is. Not at once can such a Utopia be realized. Too many years have gone into the present system, too much is the rut of public opinion fixed in the idea of a private nurse for every patient, too much is the rut of nursing experience fixed in the idea of continuous service to the patient, to make possible a reconstruction in a short period.

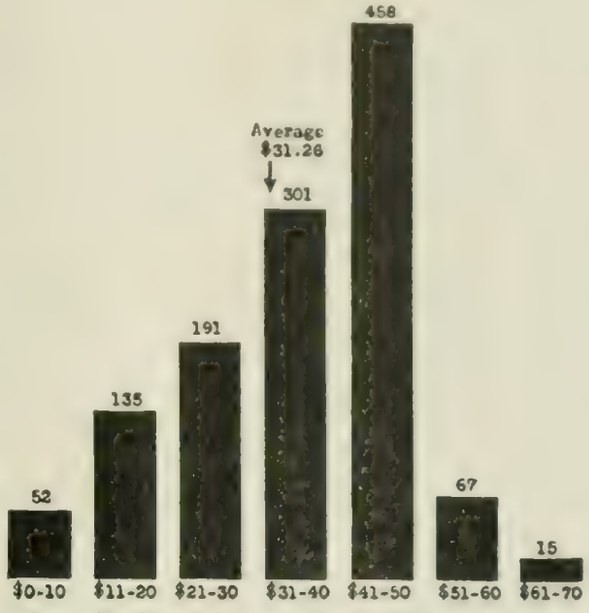
The solutions indicated by our present knowledge are:

1. Centralization of nursing resources under central registries or associations organized to distribute economically various grades of nursing service.
2. Group nursing in hospitals.

A Central Clearing House

It is not possible without experimentation and demonstration to outline the details of this centralization and distribution of forces. In general, however, it involves the principle of a central clearing house where all nurses who wish to be connected with the sick patient in the community may register. This appears to be the first and immediate step in this scheme. When the physician wants a nurse for his patient, instead of calling a half dozen numbers until he finds what he needs, he calls one central clearing house or registry. Such a registry, through its entrance requirements, could ultimately institute teaching supervision on the same basis that it is done in visiting nurse associations.

Not only should graduate nurses be invited to register, but the undergraduate, the trained



Number of private duty nurses in New York State who earned each amount of money during last week in February, 1926. 52 nurses earned $10 or less. 82 earned $50 or more. Of those 82, 80 were in Brooklyn or New York City.

attendant, the nurse's aid, as well; for all illness does not require the services of the skilled nurse. In many homes where the housekeeper is ill, the need frequently demands housekeeping as well as nursing service. There is a steady demand for this type of worker—the practical nurse. This work has been highly unstandardized, for the worker belongs to no group. She stands alone. Not only should she be brought into the field where constructive supervision can be maintained, but every effort should be made to develop her, in order to answer the community's demand for her services.

Organized Hourly Nursing

The next step that is indicated marks the radical change from nursing our patients on a twelve- or twenty-four-hour basis regardless of what is their need, to nursing them in accordance with the actual number of hours' service they need. That is, instead of nursing them by the day, we nurse them by the hour. Hourly nursing is not a new thing. Our visiting nurse associations are more and more developing this service in answer to the

demand of the patient who is able to pay for the hourly service but who cannot pay for and does not need a nurse on a twelve-hour basis. The steady growth of this service in our visiting nurse associations indicates that the community has tried it, and has found it good, and wants more of it. The Philadelphia Visiting Nurse Society reports, for instance, that in 1919, when its hourly service was inaugurated, it sold 3,335 hours of nursing, while in 1925, this was more than doubled —6,869 hours.

Miss Katharine Tucker, the general director of the Society, writes:

> Its use, however, is not limited just to the person of moderate means, but to the person who could pay for the full time for a nurse if full time were needed. It is most extravagant in money and skill to tie up a nurse for twenty-four hours when two hours of trained nursing service is all that is required . . . . it is used by all kinds of people —very wealthy, and the salaried, moderately circumstanced, as well. I feel very strongly this is the beginning of the only sound answer to the whole question of adequate nursing service for the community.

Hourly nursing service, to be successful, needs to be carried on through an organization. Through organization, the overhead, the losses, and the cost of developing new types of services, is spread over a large number of visits, thereby making the cost per visit lower to the patient than if he were dealing individually with the individual nurse. Furthermore, through organization, the standards of work are uniform, and policies and ideals compatible with the best interests of the community are maintained. The nurse is on salary, she is on a regular schedule of work, she is given vacations and sick leave on pay, she has opportunity for promotion, and through supervision she is constantly kept in touch with newer developments and practices in health work. The visiting nurse operates on such a basis and she is one of the happiest, yet hardest working, in the profession today.

Whether much of the community's demand for hourly service could be rendered through an extension of the visiting nurse association's work, or whether it should be done entirely through the registry, or whether there should be joint effort between registry and visiting nurse association, remains to be determined. The first step in the direction of hourly nursing is the realization on the part of the public, physician, patient, and nurse alike, that it seems inevitable that the bulk of our nursing will in the future be done on this basis.

The administrative difficulties of developing an hourly nurse service, elastic enough to cover twenty-four hours a day, to cover emergencies, etc., and yet not so elastic as to make the cost prohibitive, are many. We doubt very much if such service could be self-supporting during the experimental stage, though we see no reason why it should not be so after the demand has been determined and the routines developed.

Group Nursing in Hospitals

We believe, however, that this development of organized, supervised, well administered hourly nursing service offers one of the ways to a solution of our problem. The other way is group nursing in the hospital, where a nurse cares for two, three, and four patients, depending on the seriousness of the illness and the patient's desire to pay. Experiments in this field have been more or less successful.

Eleanor Hamilton of the Edward Sparrow Hospital, Lansing, Michigan, reports, in the January, 1926, issue of *The American Journal of Nursing*, the success of her experiment in group nursing. Sister Domitilla of St. Mary's Hospital, Rochester, Minnesota, also reports in the same issue, the success of the group nursing scheme inaugurated in her hospital during war days and which continues to the present day.

When group nursing has been unsuccessful, one reason has been the lack of teamwork; some one of the participants, the patient, the doctor, the hospital administrator, or the nurse, has not been wholeheartedly a part of the scheme. Another reason for failure has been the effort to put group nursing on a twelve-hour basis. This is utterly unsound. The nurse caring for three patients, on an eight-hour shift, is active a major portion of those eight hours—there is little sitting about waiting for the patient to need something. A twelve-hour day is dangerous to patient and nurse alike. Under this plan, the nurse is on a yearly salary to the hospital and she is directly responsible to the administrative heads of the institution. As in the development of hourly nursing, the administrative and other difficulties of such a scheme are many. It will take time to obtain whole-hearted coöperation on the part of the patient, doctor, administrator, nurse, alike. To those who have studied the situation, however, the new order of things makes such developments seem inevitable.

Private duty nursing ministers to a great human need; it must keep pace with the progress in adjoining fields. Waste, especially in a service so important to human welfare, cannot be endured. Commercial agencies have been quick to organize household servants and part-time workers on an hourly service basis. Can we afford to have them seize this opportunity for

organizing nursing on the same basis? Have our patients not suffered enough from the commercialism and the lack of standards of many of the commercialized nursing registries?

What will happen, you may ask, to the nurse who desires neither the group nursing nor the hourly nursing scheme? We can see no reason why she should not carry on as she is doing today, though we urge her to become a part of this central registry. Ultimately we believe the public will become accustomed to purchasing its nursing service from an organization rather than from an individual, and it will be to the best interests of the individual nurse to be a part of such an organization.

There will always be the patient who requires full time service for the nurse who wants to do continuous duty rather than hourly work or group nursing.

The organizing and strengthening and broadening of the central registry is the first step. It is the thing we can do today in building for our tomorrow. It is the thing in which every nurse can participate—it is her responsibility to do so.

Organization Increases Demand

Will this new order of things, with an economic distribution of nursing service, bring about such a saving that many nurses will find themselves without work? Before the days of the public school, only children of the more prosperous citizens could afford the private school or the private teacher. The number of teachers available was in proportion to this demand. With the organization of the public school system, with education available for all, necessarily the work of the private teacher was taken over by the community. Did this work to her disadvantage? Because education was available to the average taxpayer, the increased demand for education multiplied the number of teachers many times. When machinery was introduced into industry and the worker, instead of turning out two of a product every day by his hands, could turn out fifty with the aid of a machine, the cry was loud and long that the labor-saving machine would throw many workers out of jobs. The exact opposite has occurred.

The demand for shoes made cheaper through machine methods has increased the number of shoe operators. The demand for newspapers, made cheaper through the great labor-saving device, the linotype machine, has greatly increased the number of workers engaged in the printing office. There has been demonstrated to us many times in the past twenty-five years the principle that as the price of the commodity has been placed within the means of the average consumer, the increased demand for it has worked to the advantage of the worker. The introduction of labor-saving devices has been a boon to every group concerned, instead of a detriment. Is it not reasonable to assume that as the cost of nursing comes within the means of the average citizen, when he can purchase one or two hours of service instead of twelve or twenty-four, he will purchase it in increasing amounts? Many are already doing so through the visiting nurse associations. We believe that many more will do so when this type of service is broadened and emphasized.

We grant that the amount of nursing service demanded is governed by the health conditions in the community. Does anyone believe that we are nursing all the sick who need our care in the community today? How many families in moderate circumstances are doing with inadequate or no nursing at all because they cannot afford or do not need the twelve- or twenty-four-hour nurse and, as has been stated before, because the nature of the illness does not demand her? The moderately ill "flu" patient, forced to remain in bed a week, is more comfortable and secure for the morning bath and rub given by the nurse in her one hour in the home, while his family brings his meals, and takes care of his minor wants. Today, if he does not call in the visiting nurse, he either goes without this care or he pays a price for it, frequently beyond his means.

Furthermore, in keeping with the modern program of sickness prevention and health promotion, the nurse does not confine herself to straight bedside nursing. The new mother wants to be taught how to bathe and give care to her baby, or how to prepare a milk formula the doctor has ordered; the tuberculosis patient and his family want to be taught how to adjust to the conditions about him.

As the demand within the home for instruction in making practical application of the findings of medical science continues to increase, the nurse finds herself always with an increasingly active job. Therefore, we believe that a more economical use of the nurse, with a cost within reasonable limit, will result in a demand for more nursing service.

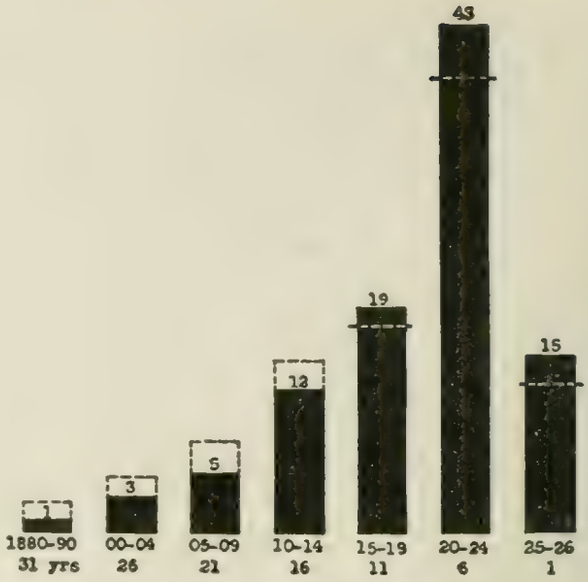
Furthermore, what is more important, it will democratize what we call private duty—not only the rich and the poor may have as much as they need of nursing, but the families of moderate means may purchase it in accordance with their needs, and not in accordance with their emergencies.

Teamwork Essential

The success of any plan for solving the problem of adequate nursing care for the community under circumstances agreeable to patient and nurse alike, depends on teamwork. The doctor, patient, public, nurse, all must coöperate in a general attack on the problem. Personalities, personal criticism, personal opinions, bitterness, dogmatism, must not enter into the solution. No one group can or should hope to work it out alone. The nurse whose whole life is centered about nursing should assume the initiative; it is her responsibility to the community. This is the responsibility not only of the private duty nurse, but of every nurse. "Private duty" is a term used to indicate under what auspices the nurse does her work, but the sick patient, regardless of the label under which he is nursed, requires the nursing care that will restore him to health.

To render adequate nursing service to the community is the responsibility of the nursing profession. Our profession stands or falls by the manner in which we serve the community. We owe it to ourselves. We owe it to the young women who today are following us out of the training schools, whose hearts are alive with hope and whose eyes are bright with desire for service. Rightly they look to us for leadership. Is it not our responsibility to clear the way for them for fulfillment of their hopes?

Let no one be discouraged by the facts that have been here put forth. Rather let us take courage because the facts concerning our work and our methods of work are coming to light. Let us be invigorated by the realization that there are no facts regarding nursing that we wish to have remain covered. There is no doubt in our minds that as nurses, physicians, and public consider



Who plan to go? Found, ■; Expected, ⬚ 564 of the 1,409 nurses plan to leave private duty nursing. Solid column shows what per cent of these 564 nurses belongs to each "years in service" group. Dotted line shows what per cent would have been expected in that group, if there were no relation between youth and hope for change. Nurses who have been in service more than 11 years tend to stay; those less than 11 years tend to go. New York State, 1926.

these facts together, and as they jointly engage in working out a solution, not only will the old mutual confidence be reëstablished, but this mutual faith will be stronger than ever. Furthermore, there is no doubt that the solution will be to the advantage of patient, doctor, and nurse. That rarely beautiful thing, the spirit of nursing, which inspired our pioneers to overcome their difficulties, abides in the nursing profession today with undiminished fire. It inspires us to accept the challenge of these difficulties, to work them out on a plane that keeps the nursing profession to us the most glorious and fruitful of all professions.

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